



Short Report

An analytical approach to clinical forensic evaluations of asylum seekers: The Healthright International Human Rights Clinic

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ABSTRACT

Healthright International, formerly Doctors of the World-USA, has for the past 15 years trained clinicians to perform forensic medical evaluations of torture survivors. As the burden of proof in asylum cases in the United States has increased, so has the scrutinizing of the evidence presented. We present a series of cases in which the scars themselves bear testimony to the applicant's case, bolstering the importance of photography in these cases.

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There are more than 22 million refugees, and 650,000 persons seeking asylum, in the world today.¹ Every day, thousands of men, women and children survive violence and flee their homelands.² They are often forced to travel in a dangerous manner and without valid travel documents, applying for asylum in the countries where they land.³ These populations are at high risk for having experienced torture.⁴

There are over 500,000 immigrant torture survivors currently living in the United States.⁵ This population is dispersed throughout the United States, though clusters are found in 10 states: Arizona, California, Florida, Massachusetts, Minnesota, Nebraska, New York, Pennsylvania, Texas and Washington.⁶ New York is a city with a large population of foreign-born torture survivors, with at least 100,000 survivors living in the New York metropolitan area alone.⁷

Healthright International (HRI), formerly Doctors of the World-USA, established the Human Rights Clinic (HRC) in New York in 1993. Its goal is to train physicians and mental health providers to bear witness to the experiences of torture survivors, perform objective clinical evaluations of asylum seekers, to write affidavits for meritorious applicants, and to testify in legal proceedings (as necessary). Clinicians at HRI are trained to perform evaluations using a standardized protocol, one based on the United Nation

Manual on Effective Investigation and Documentation of Torture and Other Cruel and Degrading Treatment or Punishment (also known as the Istanbul Protocol).⁸ Evaluations typically require 2–3 h. Most volunteers meet with the applicant to perform their assessment in one session. Since its inception, the HRC has trained over 400 physicians and mental health professionals, and provided evaluations to over 2000 torture survivors from over 100 countries. Over the past 14 years, the HRC has shown remarkable success: 85% of torture survivors with an HRC affidavit are granted immigration relief, compared to the national average of 23%⁹ which is comparable to the experience of others.¹⁰

Torture survivors seeking asylum in the United States are typically examined months or years after the purported torture has occurred. In a systematic chart review of the forensic evaluations of asylum seekers seen in the Human Rights Clinic in the Bronx, applicants were examined, on average, 2.9 years after entering the United States, commonly several years after the alleged maltreatment.¹¹ For these reasons, physical clinical forensic findings of asylum seekers are almost always limited to the late manifestations of torture.

The recent enactment and broader enforcement of stricter immigration laws place added burdens on asylum seekers. The Illegal Immigration Reform and Immigrant Responsibility Act of 1996 mandated that anyone entering the country without documentation would be subject to deportation¹² resulting in mandatory detention under conditions akin to prison. Furthermore, the Real

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ID Act of 2005 gave immigration judges and asylum officers broad discretion to reject asylum claims based on demeanor of the claimant or witnesses further codifying the need for corroborative evidence in asylum cases.¹³ For torture survivors, such substantiating evidence may sometimes be found on physical examinations abetted by photographic documentation.

Physicians who conduct examinations of asylum applicants face a number of challenges. These include time constraints to perform evaluations, limited access to applicants, the need for rapid submission of affidavits, language and cultural barriers, and the emotionally difficult nature of working with torture survivors. Once the evaluation is performed and the affidavit submitted, healthcare providers face challenges from the legal system as well. Our HRC volunteer physicians are considered by the courts to be defense witnesses, and sometimes their objectivity is questioned. In addition, the qualification of some of our HRC examiners has been challenged in US immigration courts on the basis that a specialty in “torture medicine” simply does not exist.

Confounding this, many torture survivors bear no physical findings of their traumas. The most common type of torture documented in asylum seekers is beating¹⁴ which often results in either nonspecific scarring or none at all.¹⁵ Indeed, these findings support the dictum that “the absence of physical findings must never be construed as evidence of absence of torture”.¹⁶

The goals of this article are threefold—to share clinical forensic findings of asylum applicants, to support an analytic approach to evaluating and reporting physical findings, and to encourage using photography as a clinical tool to assess torture survivors. Since the forensic examiner in immigration cases must present findings to a non-medical and sometimes skeptical audience, we believe it is in the applicants’ interest for us to present the evidence in a clear fashion, such that the wound patterns could be evident even to the unpracticed eye. Lastly, in the absence of convincing forensic evidence, the examiner should review the history aiming to detect a unique historical element as exemplified by our final case. (Notte benne – although there is no international consensus¹⁷ for the descriptive terminology to be used in forensic findings of asylum applicants, and not yet a standard in US immigration courts, we have applied the terms from the Istanbul Protocol format for forensic examiners in the cases below.)

1. Case 1

An Egyptian Coptic Christian was attacked by Muslim fundamentalists wielding a knife. The applicant describes that to protect himself from the blow; he extended his left hand in a defensive



Fig. 1. Scar on inner wrist outlines shape of the tip of a knife.

posture. The knife penetrated his leather jacket and cut him, digging into his left wrist. He did not seek medical attention and the wound healed slowly over 25 days. At examination the applicant showed the scar (Fig. 1) and also demonstrated the means by which he defended himself (Fig. 2).

Close examination of the ventral aspect of the wrist reveals a small triangular scar. There are several significant features of this scar. Its triangular shape reflects the tip of a knife. It is a small depressed scar, highly consistent with the tip of a knife digging into the skin, as opposed to a long linear laceration from, say, a slashing wound. The scar demonstrates evidence of closing by primary intention, without the aid of sutures. In addition, the unique location of the scar, on the ventral surface of the wrist, is compatible with the applicant description and demonstration of how he held out his hands to protect himself during the attack.

2. Case 2

A Guinean man reported that he was tortured by the military over 2 years. He describes that on numerous occasions he was restrained and then burned with the hot flat tip of a variety of metal rods that had been resting in a fire. At times he was forced to stare into the eyes of his torturer as the hot iron was pressed held to his skin. The burned areas formed blisters which he lanced and drained.

Physical examination revealed numerous scars on the lower legs. Many of the scars were circular reflecting the shape of the end of the metal rods. In addition, there was a unique scar on the left lower leg (Fig. 3). This scar was a depressed circular 2.5 cm² with central hypopigmentation and with discrete dark margins. In addition, there was a distinctive hyperpigmented mark, an inverted cross (Fig. 3, arrows), within the scar.

This scar has several significant features that could lead an examiner to conclude that this finding is diagnostic according to Istanbul Protocol criteria. The shape of the scar is an almost perfect circle and full thickness burn injury is suggested by hypopigmentation and depression. In the center are two wide, hyperpigmented intersecting lines at a 90° angle which may be attributed to the structural nature of the end of the heated rod.

Unique scars like these, with unusual or specific shapes, have been previously reported in torture survivors.¹⁷

3. Case 3

A Somali man reported that he was burned repeatedly with a long thin hot metal rod. The rod had been heated in a fire. The



Fig. 2. Applicant demonstrating defensive posture. This photo was included in the medical affidavit.



Fig. 3. Arrows point to faint inverted T-shaped scar in an otherwise hypopigmented scar. The immigration judge praised the inclusion of the photograph in the affidavit.

tip of the heated rod and the length of it were both against his left chest in the anterior axillary line.

Examination of his thorax revealed numerous long, slightly depressed, hyperpigmented scars (Fig. 4, long arrows). They measured 8–10 cm in length and 1 cm in width. A shorter scar (Fig. 4, short arrows) was noted underneath the longer scars. It measured 1 cm in width corresponding to the 1 cm width of the longer scars at their widest. There are several distinct features of these scars. The scars are mildly depressed and hyperpigmented which are highly consistent with a burn. Although the searing object was linear, the scars taper at both ends. This is due to the geometric aspects of the injury. The heated object was straight and the area traumatized was curved. Greater scarring occurred at the center of the wounds than in the periphery due to the increasing distance of the heated rod from the skin. A similar pattern has been observed in a “boat shaped” burn scar from a glowing rod held to the soft part of a calf.¹⁸

4. Case 4

This man's village in Sierra Leone was attacked by rebels. They tied him tightly with a thin rope such that his elbows were virtually touching each other behind his back. They then threw water on



Fig. 4. Scarring due to heated cooking iron: the long arrow and the short arrow correspond to scarring from the length of the bar and the tip of the bar, respectively.

the rope to cause it to tighten further cutting into his arms which bled. He experienced shortness of breath which eased later when the ropes were cut. His arms were so weak afterward that he had difficulty holding a spoon for a number of months.

Close inspection shows that the scars encircling the arms above the elbow (see Fig. 5) may be considered diagnostic of restraint tattoos due to a rope since they bear unique a forensic signature that, to our knowledge, has not been previously described in the literature. The scars demonstrate notching in a regular fashion. This is attributable to the braiding of the tight rope which left regular impressions in his skin, but also spared the skin where the rope braids crossed over each other. Also of note, the applicant's report of dyspnea when restrained is compatible with his description of having his arms tightly bound behind his back. This body position limits full expansion of the thorax during inspiration, causing dyspnea. The mechanical restraints encircling the limbs may have also stretched the brachial plexus or compressed nerves resulting in the transient neurologic upper limb deficits.

5. Case 5

A man from a minority tribe in Nigeria was targeted by the police as a result of his political activity in favor of more equitable



Fig. 5. Restraint tattoos on both arms just proximal to the elbows. The regular notching, best seen on the left arm, is a permanent impression of the braided rope.

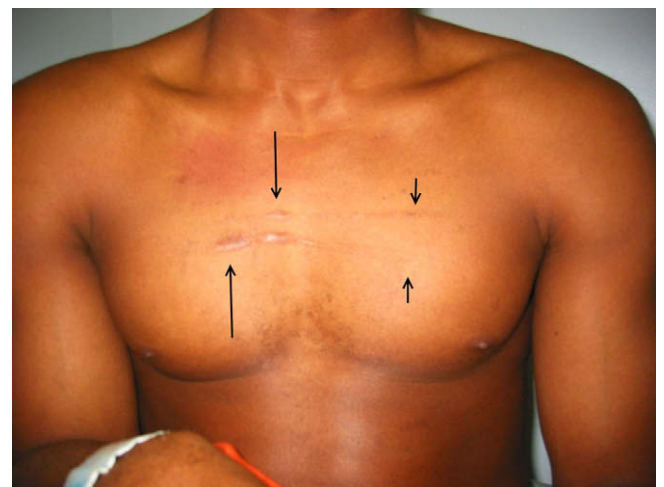


Fig. 6. Keloids (longer arrows) signify greater scarring in this Nigerian man who was marked as a troublemaker. The scars trail off to the right (short arrows).

distribution of oil profits. He was arrested and tortured including whipping and forced positions. Prior to being released he was given a warning and the police then slashed his chest with the jagged edge of a broken bottle to mark him as a troublemaker. A sandy substance was then rubbed into the wound causing further pain.

Physical examination demonstrated two somewhat jagged scars 0.5 × 10 cm (Fig. 6). Scars were thicker with keloid formation on the right (long arrows) but tapered to thin lines on the left chest (short arrows). The applicant reported that the attacker cut him from the right to left chest and that with each cut he tried to pull away resulting in a smaller scar on the left chest.

In comparison, another applicant had chest scars that were bilateral and symmetric (Fig. 7). These were virtually identical in length and position over the nipple. Though this applicant claimed these were scars from an attack the examiner felt otherwise. They were identified later to be tribal markings.

6. Cases 6 and 7

A woman from Cameroon was arrested and taken to a police station without explanation. Two policemen entered her cell and began whipping her. She ran around the room trying to escape the blows. One of the whips was fairly long and perhaps a bit thicker than a typical electrical cord. The second was short and fat. It was perhaps 1" thick with a metal circular object at the tip. The whipping proceeded for 30 min. Examination revealed numerous linear scars of varying thickness. One scar (Fig. 8) was much wider at one end than the other. One end was hypertrophic (short arrow) while the other was much thinner and fainter (long arrow). She sustained a unique scar pattern reflecting lacerations of differing morphology because she was not stationary during the assault.

A Liberian man was attacked by a group of Guineans in the street. He was punched, kicked and beaten with a thin tree branch. The lacerations healed over time and he applied a salve to them. He was examined 4 months after the beating. Examination showed a left forearm scar (Fig. 9), hypertrophic and tender at one end, thin and nontender at the other.

Pathologically, there may be some confusion between keloids and hypertrophic scarring¹⁹ but the two are considered distinct clinical entities. Hypertrophic scars are elevated but stay within the bounds of the initial tissue injury while keloids extend beyond the borders into healthy connective tissue. Hypertrophic scars may be pink or pruritic and often recede with time whereas keloids rarely regress.²⁰ Scar pattern injury interpretation may be ham-



Fig. 7. Bilaterally symmetric scars are almost always indicative of tribal markings.



Fig. 8. Broad scar (smaller arrow) attached to a thin tail (long arrow). This pattern is seen in some whipping injuries.



Fig. 9. Wider portion (long arrow) of a scar attributed to a whipping leads into the thin end of the scar (short arrow).

pered by keloid formation but abetted by hypertrophy, as in these two cases. The differential diagnosis of hypertrophic scars include keloids, dermatofibroma, connective tissue nevus, fibromatosis and other dysplastic tumors.²¹

Whips and other pliable blunt weapons have been reported to produce elongated or tram line scars.¹⁷ The two cases presented here demonstrate that a scar, seemingly from a single blow, may appear strikingly different from one end to the other. We believe the initial blunt force of a whipping injury or glancing blow may occasionally lead to thickened scar formation at the presumed point of impact. The greatest injury would naturally occur at the leading edge of the wound causing scar thickening. As the kinetic energy is dissipated, there is less tissue injury, and as a result the end portion of the scar resembles a thin tail. Clearly this is a variant of a pattern seen in those prone to hypertrophic scarring and may only be seen in some of the scars in a given individual.

7. Case 8

A Hindu man in Bangladesh was tied with his back to a tree. His hands were bound behind his back. Two ropes were tied tightly around his neck and the tree—one rope below the larynx and the other above. The examiner asked a simple open-ended question: "What did you feel?" The applicant had experienced pain and dysp-

nea but most vividly recalled drooling all night. He also had an audible click with swallowing. There were no other significant findings on examination but nonetheless the examiner was able to assert that the report of drooling due to a trapped larynx was such a unique historical element that only one who had experienced such a trauma would be able to recount such a detail. Asylum was granted. Of note, this case has been presented to hundreds of clinicians training in our forensic program with only two able to contemporaneously surmise drooling as the chief complaint.

This case exemplifies the importance of returning to the most rudimentary aspects of medical training in examining asylum seekers—namely not presupposing knowledge of another's experience. It should be emphasized that, if there are no supportive findings on physical examination, revisiting the history with a few open-ended questions may aid elucidating the applicant's narrative in ways that one may not even be able to imagine.

8. Discussion

The growth of clinical forensic medicine has been attributed in part to the evidentiary needs of prosecuting attorneys²² in criminal cases. Successful prosecution is significantly correlated with extent of injury documentation.²³ The more detailed an examiner's report, the less likely it is that the examiner will be called to testify.²⁴ Patterns of injury recognition and documentation with digital photography are also recognized as integral elements of the forensic examinations.²⁴

Survivors of torture, however, present challenging forensic examinations²⁵ due to the time lapse between injury and examination as well as the tendency for some manners of torture not to leave clear permanent sequelae. As one of the younger subcategories of clinical forensics, there is also a need for greater documentation of injuries in asylum cases, and for publication in the literature.

In this article, we have presented a series of images of varying morphology but all have patterns indicating a mechanism of injury, torture implement used, or defensive position maintained by the survivor. The high proportion of African patients described in this article is a reflection of their tendency towards hyperpigmentation and hypertrophic scarring.

It should be noted that, for most of the cases described above, the patterns of injury were not obvious to the examiner at the time of the applicants' interview, but rather became apparent when the images were reviewed during report preparation. This underscores the importance of using photography as a clinical forensic tool in these cases. Many of the images presented in this article are regrettably blurred due to use of an auto focus digital camera. We encourage all of our medical volunteers to use a digital camera (preferably manual focus) as a clinical forensic tool. Close inspection of photographs can aid examiners to identify scar patterns. Some of the scar patterns may be so unique as to be a virtual fingerprint of the initial trauma.

Conflict of Interest

None declared.

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Ethical Approval

Not applicable.

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